

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013898

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No.

318
FILED MAR 28 1963

Primary Registration District No.

1003

Registrar's No.

3308

STATE FILE NUMBER

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
Length of stay in 1b 45 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital		d. STREET ADDRESS (If outside, give location) 4548a Clarence Ave.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last TIMOTHY JOSEPH SULLIVAN			4. DATE OF DEATH Month Day Year March 20 1963
5. SEX Male	6. COLOR OR RACE Caucasian	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/11/1894
9. AGE (last birthday) 68		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Tavern	
11. BIRTHPLACE (City and state or country) County Kerry, Ireland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Michael Sullivan		13b. MOTHER'S MAIDEN NAME Mary Sullivan	
14. NAME OF HUSBAND OR WIFE Kathleen Sullivan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> W.W.I	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Kathleen Sullivan 4548a Clarence Ave.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of bladder c metastasis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): DUE TO (c): 181.0		INTERVAL BETWEEN ONSET AND DEATH 1961	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Terminal Pneumonia			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 9-7 1961 to Mar 20 1963 and last saw her/him alive on Mar 19 th 1963 Death occurred at 6-6:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Dr. C. A. Lindeman M.D.		22b. ADDRESS 4126 ^a Shreve Ave	
22c. DATE SIGNED 3/2/63		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE March 23, 1963		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
23d. LOCATION (City, town, or county) St. Louis, Mo.		23e. DATE RECD. BY LOCAL REG. MAR 21 1963	
24. FUNERAL DIRECTOR [REDACTED] 3840 Lindell Blvd.		25. REGISTRAR'S SIGNATURE [REDACTED] M.D.	

USE BLACK INK

OR

TYPEWRITER RIBBON

Dr. Carl Lindeman
4126^a Shreve
Hours - Thursday
10-12 2-4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Francis Hallbomson

Licensed Embalmer No.

3565

P. O. Address

3840 Lindale

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.